DOCUMENT RESUME

ED 369 361 HE 027 400

TITLE	State University of New York Health Science Center at Brooklyn: Selected Contracting and Expenditure Controls. Report 93-S-50.
INSTITUTION	New York State Office of the Comptroller, Albany. Div. of Management Audit.
PUB DATE	8 Apr 94
NOTE	30p.; For related documents, see HE 027 397-399.
PUB TYPE	Reports - Evaluative/Feasibility (142)
EDRS PRICE	MF01/PC02 Plus Postage.
DESCRIPTORS	Accounting; Bids; *Contracts; Costs; *Expenditures; Facility Inventory; *Financial Audits; Food Service; Higher Education; *Hospital Personnel; Medical Schools; Nursing; Payroll Records; Purchasing; *Teaching Hospitals

ABSTRACT

This audit examined State University of New York (SUNY) at Brooklyn's University Hospital's controls over contracting for food and nursing services, sole source contracts, accounts payable controls, supplies inventories, and equipment inventories. It examined selected practices from April 1, 1990, through March 31, 1993, through staff interviews, review of records, and comparison with comparable costs at similar facilities. The audit found that the Hospital had not made enough effort to attract qualified bidders before it awarded contracts. At the time of the food service contract renewal the Hospital received only two bids. The audit also found that the Hospital did not award per-diem nursing contracts to the lowest bidder and could not explain why certain bidders were disqualified. In addition, nursing staff were permitted to work for contractors outside their regular hours resulting in the Hospital paying nursing contractors for services not provided making a total overpayment of about $35,000 during the audit period. The audit also found that the Sterile Supply Unit was significantly overstated in value. Regarding equipment, some improvements were needed to ensure that new items were recorded on control records and that items removed were eventually returned. SUNY officials agreed with the report and their comments are included. (JB)

HE

State of New York
Office of the State Comptroller

Division of Management Audit

Report 93-S-50

Dr. Joseph C. Burke
Interim Chancellor
State University of New York
State University Plaza
Albany, New York 12246

Dear Dr. Burke:

The following is our report on the University Hospital at Brooklyn's controls over selected contracting and expenditure activities.

This audit was performed pursuant to the State Comptroller's authority as set forth in Section 1, Article V of the State Constitution and Section 8, Article 2 of the State Finance Law.

This report was prepared under the direction of John T. Walsh, Audit Director. Major contributors to this report are listed in Appendix A.

Office of the State Comptroller
Division of Management Audit

April 8, 1994

Executive Summary

SUNY Health Science Center at Brooklyn Selected Contracting and Expenditure Controls

Scope of Audit

The Health Science Center at Brooklyn (Center) is one of four health science centers operated by the State University of New York (SUNY) and includes a hospital, three colleges and a graduate school. The University Hospital (Hospital) is a 406-bed tertiary care facility providing third-level care for complex medical cases.

During 1991, the Hospital reported an operating loss of $52 million. These losses were mostly offset by subsidies from the State, which have grown during the past three years from $37 million in 1989 to $43 million in 1990, and to $49 million in 1991.

Our audit addressed the following question about the Hospital's operations:

- Are there adequate controls over contracting and expenditure activities related to selected contracts and for the maintenance of selected inventory and equipment.

Audit Observations and Conclusions

To obtain reasonable prices for services and prevent fraud and favoritism in the awarding of contracts, SUNY guidelines require that SUNY facilities solicit bids from a sufficient number of qualified vendors – a minimum of five sealed bids when awarding contracts for services in excess of $10,000. We reviewed the contractor-selection procedures used by the Hospital in expending almost $17 million for miscellaneous and special departmental contractual services from July 1, 1991 through June 30, 1992. We found that the Hospital had not made enough effort to attract a sufficient number of qualified bidders before it awarded service contracts.

The Hospital spent about $3.5 million for food services during 1992. At the time of our audit, the Hospital was in the process of awarding a new contract to its current food service vendor for the preparation of patient meals, operation of the cafeteria, and catering of departmental functions. Although the Hospital issued Requests for Proposal (RFP) to 15 companies, only 2 bids were received. We believe the Hospital did not solicit bids from enough qualified vendors to ensure that the contract was awarded at the lowest possible cost. For example, we noted that an RFP was sent to six vendors who did not service health care providers and two others who were no longer in business or had moved from the address where the RFP was sent. Two other non-responsive vendors stated

that they had been interested in bidding, but were not given enough time to prepare a bid proposal. Yet, an RFP was not sent to another vendor that provides food service for the University Hospital at Stony Brook for just $21.67 per patient day - much less than the $29.90 bid by the Hospital's current vendor. (See pp. 3-4 and 10)

The Hospital did not award per-diem nursing service contracts to the lowest bidders, and was unable to explain why certain bidders were disqualified. We also noted that during the first year of the contract period, 62 percent of the $3.8 million paid to nursing contractors went to the most expensive of the five agencies that were awarded contracts. In response to a draft of this report, SUNY officials stated that they have made every effort to use the lowest bidding nursing agencies; however, these agencies often were unable to supply nurses timely and reliably. As a result they utilized the higher-bidding contractors who were able to fulfill their contractual obligations.

Our audit found, however, that the Nursing Department did not have an adequate system to ensure that the lowest-priced vendors were contacted first and given an opportunity to fulfill their obligation. In many instances we could find no evidence that the Nursing Department even contacted the lowest-priced contractor. In other cases, the Nursing Department did not allow sufficient time for a contractor to respond before contacting the higher-priced contractor. (See pp. 4-5 and 7-9)

Hospital nursing staff are permitted to work for nursing contractors outside of their regular hours. We found some instances where this practice resulted in the Hospital paying nursing contractors for services not provided. In these cases, contractors have billed the Hospital for hours worked by Hospital nursing staff that overlapped hours the employees claimed to have worked while on the State payroll. Based on our review of a sample of vouchers, we estimate that the Hospital overpaid these contractors by more than $35,000 during our audit period. (See pp. 9-10)

As of December 31, 1992, the Sterile Supply Unit valued its inventory at $881,000. However, due to unrecorded issuances of supplies and erroneous handling of unit costs in inventory records, the value of the inventory was significantly overstated; by over $130,000 within our audit sample of items. Concerning equipment, some improvements were needed to ensure that new items get recorded on control records and that items removed from the facility are eventually returned. (See pp. 15-21)

Comments of SUNY Officials

SUNY officials generally agreed with our recommendations. Regarding the use of the most expensive nursing service contractors, they stated that the Hospital made every effort to use the lowest available bidder who could supply qualified nurses in a timely manner.

Contents

Introduction

Background

The Health Science Center at Brooklyn (Center) is one of four health science centers operated by the State University of New York (SUNY) and includes a hospital, three colleges and a graduate school. The University Hospital (Hospital) is a tertiary care facility providing third level care for complex medical cases. It has 406 beds and provides ancillary services such as laboratory, pharmacy, radiology, referred ambulatory surgery, chronic renal dialysis and routine nursery care.

During 1991, the Hospital reported an operating loss of $52 million. These losses were mostly offset by subsidies from the State which have grown during the past three years from $37 million in 1989 to $43 million in 1990, and to $49 million in 1991.

Audit Scope, Objectives and Methodology

Our audit examined selected operating practices at the University Hospital at Brooklyn from April 1, 1990, through March 31, 1993. The objective of our audit was to determine whether there were adequate controls over contracting and expenditure activities related to selected contracts and for the maintenance of selected inventory and equipment. To accomplish our objective, we interviewed staff, reviewed records pertaining to financial transactions, and compared certain operating costs at the Hospital with comparable costs at other health-related facilities.

We conducted our audit in accordance with generally accepted government auditing standards. Such standards require that we plan and perform our audit to adequately assess those operations which are included within our audit scope. Further, these standards require that we understand the Hospital's internal control structure and its compliance with those laws, rules and regulations that are relevant to the operations included in our audit scope. An audit includes examining, on a test basis, evidence supporting transactions recorded in operating records and applying such other auditing procedures as we consider necessary in the circumstances. An audit also includes assessing the estimates, judgment and decisions made by management. We believe that our audit provides a reasonable basis for our findings, conclusions and recommendations.

We use a risk-based approach to selecting activities to be audited. This approach focuses our audit efforts on those operations that have been identified through a preliminary survey as having the greatest

possibility for needing improvement. Consequently, by design, finite audit resources are used to identify where and how improvements can be made. Thus, little audit effort is devoted to reviewing operations that may be relatively efficient and effective. As a result, our audit reports are prepared on an "exception basis." This report, therefore, highlights those areas needing improvement and does not address activities that may be functioning properly.

Response of SUNY Officials to Audit

A draft copy of this report was provided to SUNY officials for their review and comment. Their comments have been considered in preparing this report and are included as Appendix B.

Within 90 days after final release of this report, as required by Section 170 of the Executive Law, the Chancellor of the State University of New York shall report to the Governor, the State Comptroller, and leaders of the Legislature and fiscal committees, advising what steps were taken to implement the recommendations contained herein, and where recommendations were not implemented, the reasons therefor.

The Process for Selecting Contractors

To obtain reasonable prices for services and prevent fraud and favoritism in the awarding of contracts, SUNY guidelines require that SUNY facilities solicit bids from a sufficient number of qualified vendors – a minimum of five sealed bids when awarding contracts for services in excess of $10,000. With these guidelines in mind, we reviewed the contractor-selection procedures used by the Hospital, in expending almost $17 million for miscellaneous and special departmental contractual services from July 1, 1991, through June 30, 1992. We found that the Hospital had not made enough effort to attract a sufficient number of qualified bidders before it awarded service contracts.

Food Service Contract

The Hospital contracts with a food service vendor to prepare patient meals, operate the cafeteria, and cater departmental functions. The contract with the vendor currently providing the service expired November 30, 1992 and the Hospital is in the process of awarding a new contract. However, the Hospital has not attracted enough qualified bidders to ensure that the contract will be awarded at the lowest possible cost.

Although the Hospital issued Requests For Proposal (RFPs) to 15 companies on its bidders list, only two bids were received. As a result, Hospital officials plan to award the new contract to the current contractor, who submitted the lower of the two bids received ($29.90 per patient day). Due to continuing contract negotiations, the old contract, which provided for reimbursement on a cost-plus basis, was extended until May 1, 1993. We noted that in the two months following the original expiration of the contract (December 1992 and January 1993), the vendor had billed the Hospital at rates exceeding $37 per patient day.

Hospital officials stated that the bidders list included 15 firms that had previously expressed an interest in bidding on the contract. Only two of these responded with a bid. Yet these officials had made no effort to contact the 13 other previously-interested vendors to find out why they had not submitted a bid. We contacted representatives from 10 of the non-responsive firms. Six stated that their companies do not service health care providers and therefore would not be interested in bidding. (However, four of the six also claimed they had never received an RFP.) Two additional firms were either out of business or had moved from the addresses where the RFPs were sent. As a result, 8 of the 15 firms solicited could not have provided the services required by the Hospital. Two other non-responsive

vendors stated that they had been interested in bidding, but were not given enough time to prepare a bid proposal.

We also noted that the Hospital did not send RFPs to food service vendors that bid at other SUNY health facilities. Specifically, we noted that the Hospital did not send an RFP to the vendor that services the University Hospital at Stony Brook for just $21.67 per patient day, a much lower cost than the $29.90 bid by the Hospital's current vendor. The Hospital also did not send an RFP to another vendor that had bid unsuccessfully for the food service contract at the Long Island State Veterans Home. As a result, the Hospital may not be obtaining the most economical services.

Nursing Service Contracts

Hospital officials contend that the Hospital cannot attract enough candidates to fill vacant nursing positions because of the general shortage of nursing personnel throughout the New York City metropolitan area, the low level of pay by State facilities, and the slowness with which the State pays overtime wages. As a result, the officials say, the Hospital must contract with nursing agencies to meet required staffing standards. During the period April 1, 1990, to November 30, 1992, payments made to such agencies totalled $10.7 million. Officials acknowledge that Hospital employees often work extra hours for these local agencies. We found that nursing managers did not follow SUNY guidelines when they awarded the nursing contracts in June 1991.

In June 1991, the Center's Purchasing Unit rebid the Hospital's nursing contracts, sending out RFPs that required bidders to provide explicit information that should be considered for the contract. The RFPs asked bidders to provide detailed information regarding their tertiary care experience, their recruitment and continuing education policies, locations where they had provided per-diem nursing staff during the past two years, bid prices for various categories of nurses and a breakdown of the employee's and contractor's share of the bid price. Fifteen agencies submitted bids and Hospital officials awarded contracts to five of the bidders.

When the Hospital selected the successful bidders for the nursing contracts, it did not adequately review the responses to the RFP. Of the five agencies awarded contracts, only three provided all of the information required by the RFP; and since one of those three had been in operation for less than one year, it could not have provided the required list of health care facilities with which it had contracted during the previous two years. This agency subsequently ceased operations during the contract period. As a result, only two of the five successful bidders appear to have met the requirements set in the RFP.

Nursing managers were unable to provide us with the methodology they used to assess the 15 bids. They could not explain why one agency that had submitted the lowest bid for 21 bid categories, and the second lowest bid for six others, was not awarded one of the five contracts. We noted other questionable practices that led to the award of the nursing contracts:

- During the previous contract period, the Hospital utilized the services of just four agencies. Nursing managers stated that they had no problem with using just four but Hospital officials nevertheless selected five agencies for the June 1991 contract. We saw no rationale for awarding a fifth contract. We did, however, note that the fifth successful bidder was an incumbent contractor.

- Some of the prices on the bid tabulation schedule (a summary of each agency's proposed rates) do not agree with the prices in the agencies' bid documents. In fact, the bid tabulation understated the prices of one successful bidder and overstated the prices of three unsuccessful bidders.

We conclude that the manner in which nursing service contracts were awarded could result in excess costs.

Sole Source Contracts

We reviewed the Hospital's procedures for awarding several contracts: one to a former employee for home dialysis services; another to a member of the Hospital's clinical practice management plan for the services of a vascular laboratory technician; and third, to the Research Foundation of the State University of New York (Foundation) for temporary financial management services. In each case, the Hospital considered the contractor to be a sole source and did not attempt to secure competition. However, the Hospital had not prepared the required written justification for this decision. We believe these services could have been performed either by hiring qualified Hospital staff or by contracting with other vendors. Without adequate competition from a variety of bidders, there is no assurance that these services were obtained at reasonable rates.

Recommendations

1. Ensure that future contracts are awarded to responsible bidders; document the selection and award process.

2. Obtain vendor competition whenever feasible. When dealing with sole source transactions, ensure that the justification is reasonable and documented.

Payments to Contractors

The New York State Governmental Accountability, Audit and Internal Control Act requires State agencies to establish a system of controls to ensure that programs are operating as intended and functioning in an economical and efficient manner. But when we reviewed the Hospital's procedures for ensuring that contractors were paid only for services actually rendered, we found that the Hospital did not monitor these contracts to ensure that amounts billed by vendors were for services actually received.

Nursing Services

Contractual nursing services are not intended as a substitute but rather supplement to services performed by State staff. Hospital policy requires that nursing supervisors first try to obtain coverage using staff employed by the Hospital (including unassigned personnel, employees who have no set schedules and work less than 20 hours per week, and regular employees working overtime) before calling contractors. However, the Hospital also allows its own nursing staff to provide extra service by working for nursing contractors outside of their regular hours. In fact, the contractor providing the majority of per-diem nursing services to the Hospital used Hospital employees to staff 356 (35 percent) of 1,012 sampled assignments. This practice lessens the pool of available nursing staff and lessens the Hospital's control over the cost of providing such services. For example, if Hospital nurses are working for the contractor, they are not available to work for the Hospital. In addition, the State is paying the contractor for overhead and profit which increases the cost. Another State agency which contracts for nursing services does not allow those contractors to employ current or recently-separated State employees.

We also found that the Nursing Department does not have adequate controls to ensure that managers obtain staff from the least-expensive contractor, whenever possible. As a result, 62 percent of the $3.8 million paid to nursing contractors during the first year of the new contract period went to the contractor charging the highest rates.

If attempts to provide adequate coverage with State employees are fruitless, nursing supervisors record coverage deficiencies in an Agency Nurse Call-in Log (Log). Supervisors then call nursing contractors by telephone; and record in the Log, the date and time, the names of the contractor and the telephone contact person. When the contractor responds that it will provide staff, the supervisor records the names of the contractor and the nursing personnel to be provided.

The Nursing Department has developed a call-in grid that defines the order in which nursing contractors should be called. The grid is a single list of the nursing contractors from lowest to highest cost (as reported by the Nursing Department). Supervisors are expected to call the lowest-priced contractor first; if they still need additional staff, they are to call the contractor with the next lowest price.

The call-in grid does not account for the different rates charged by contractors for the different types of nursing personnel provided (i.e., registered nurses, licensed practical nurses, nurse's aides, etc.) or the type of tour required (i.e., night, day, evening, regular day or holiday). The same grid is used in all cases, even though the first contractor on the call-in grid may not offer the lowest rate for the position to be filled. To reduce the cost of obtaining required staff, the Nursing Department should develop a series of call-in grids to account for each of the different rate categories.

For example, since the nursing contracts were awarded, the third contractor on the call-in grid has ceased operations. In addition, Contractor No. 5 has lowered its fees for all categories (except for critical care registered nurses) to hourly rates that are $0.05 less than those charged by Contractor No. 4. As a result, the original Contractor No. 5 has become the new No. 3. However, we noted that 62 percent of the payments to this contractor have been for critical care registered nurses for whom the pay rate was actually $2.45 higher than that of Contractor No. 4. We estimate that the Hospital could have saved more than $26,000 during the three-month period ended November 30, 1992, by obtaining critical care registered nurses from Contractor No. 4 instead of the one now considered to be No. 3.

The Nursing Department also does not have adequate controls for ensuring that supervisors call nursing contractors in accordance with contract terms. According to the RFP, contractors were required to confirm whether they could fill requested positions within two to four hours, depending how soon the position needed to be filled. We noted that the time interval between calling the first and subsequent contractors on the grid was sometimes as little as five minutes. For example, on November 9, 1992, the Hospital called the first contractor on the grid at 11:20 a.m. and the second at 11:25 a.m. for coverage on November 10, 1992 and November 11, 1992. The supervisor called a third contractor 90 minutes later. We also found that on many occasions nursing supervisors did not record their telephone calls to contractors in the Agency Nurse Call-In Log. One contractor we spoke to, who is ranked second on the call-in grid, complained that nursing supervisors do not allow enough time for a response to personnel requests. The contractor argued that it could provide more staff if the Hospital would allow adequate response time.

In response to a draft of this report, SUNY officials stated that they have made every effort to use the lowest bidding, per-diem nursing agencies; however, these agencies often were unable to supply nurses timely and reliably. As a result, they utilized the higher-bidding contractors who were able to fulfill their contractual obligations. SUNY officials indicated that they were confident that they acted in the most effective manner in securing nursing services to augment in-house personnel.

Our audit found, however, that the Nursing Department did not have an adequate system to ensure that the lowest-priced vendors were contacted first and given an opportunity to fulfill their obligation. In many instances we could find no evidence that the Nursing Department even contacted the lowest-priced contractor. In other cases, the Nursing Department did not allow sufficient time for a contractor to respond before contacting the higher-priced contractor. During the audit, in reaction to our observations, Hospital officials revised the call-in grid used to identify the lowest-priced contractors to accurately show the order in which contractors should be contacted.

We also found that the Hospital has paid nursing contractors for services not provided. In these cases, contractors have billed the Hospital for hours worked by Hospital nursing staff that overlapped hours the employees claimed to have worked while on the State payroll. We reviewed 10 of the 324 vouchers paid to nursing contractors between April 1, 1990, and November 30, 1992. Of the 365 occasions included on the 10 sampled vouchers in which Hospital employees were involved, we found charges for overlapping hours in 16 cases. Based on this sample, we estimate that the Hospital overpaid these contractors by more than $35,000 during our audit period. We also note that since these assignments were not provided, there may have been an impact on patient care.

In one case, a nurse's aide recorded on her State time sheet that she worked 7.5 hours of overtime from 3:30 p.m. to midnight, on May 19, 1990, May 20, 1990, and May 21, 1990 (a total of 22.5 hours). This same employee signed her name on a contractor sign-in sheet, indicating that she worked those same hours for the contractor. The nursing contractor billed the Hospital for $95.48 for each of these three shifts, and the employee's supervisor approved the contractor's invoice for payment. As a result, the Hospital paid the contractor for services that were clearly not provided. Furthermore, if the contractor assignment was necessary to meet required staffing standards, then one of the two units to which she was simultaneously assigned must have been short-staffed.

In our sample, we identified three other occasions of duplicate payment of entire shifts for this employee and one such occasion for another. The remaining nine overpayments were for periods ranging from one-half hour to two and one-half hours.

Nursing managers were not able to explain how these overpayments occurred. However, we noted that the Nursing Department does not compare employee timesheets and contractor sign-in sheets to prevent this type of overpayment.

Food Services

During 1992, the Hospital spent approximately $3.5 million for food services. The food service vendor is paid on a cost-plus basis. The vendor is reimbursed for all expenses incurred while preparing inpatient meals, operating the Hospital's cafeteria, and catering departmental functions, plus $0.13 per inpatient meal and 5 percent of net food service receipts.

We found that the Hospital does not verify the accuracy of any of the costs submitted by the food service contractor. The individual responsible for reviewing and approving costs told us that he only "eyeballs" the monthly food statements and looks for anything unusual. We reviewed a monthly statement and found the following discrepancies:

- The vendor did not supply documentation to support adjusting entries and home office expense allocations; and

- Weekly distribution journals prepared on-site by the contractor did not reconcile with monthly journals prepared by the contractor's home office, and neither reconciled with the monthly profit and loss statement.

Although a Hospital official stated that he had reviewed the monthly statement, he was unable to explain why certain expenses were necessary. One of these charges was for a loss on asset disposal. This expense is unusual, since the contract provides that the Hospital will furnish all equipment required for the food service operation. Therefore, a loss on disposal of vendor equipment would not appear to be reimbursable under the contract.

The problems we identified are the same as those identified in a review conducted by the Center's own Internal Audit Unit. Internal Audit noted that the vendor had no incentive to control costs. In fact, the vendor incurred losses in its non-inpatient food service operations at the Hospital. We also noted that the Hospital did not take sufficient action to minimize food service costs. The vendor reported that it cost an average of $31.23 per day to feed each

inpatient during the fiscal year ending June 30, 1992. However, we noted that the vendor submitted a bid for the new contract period at a flat rate of $29.90 per inpatient day. Apparently, the vendor believes it can feed inpatients for $1.33 less per day (a difference of almost $132,000 annually). We also compared the average cost of raw food per patient day reported by the vendor for the fiscal year ending June 30, 1992 to the average cost of raw food reported by nearby Kingsboro Psychiatric Center for its fiscal year ending March 31, 1992. The Hospital expended $12.28 per inpatient day, whereas Kingsboro Psychiatric Center was able to purchase its food for only $4.31 per inpatient day (a difference of more than $789,000 annually).

Other Services

The contract for vascular laboratory services requires that a member of the clinical practice management plan provide the services of a full-time vascular laboratory technician. A Hospital official stated that he approved invoices submitted by the vendor so long as the amount billed remained constant from month to month. He did not compare vendor billings to the technician's timesheets or other records to verify that the services were actually provided full-time.

Recommendations

3. Consider requiring that subsequent contracts with nursing contractors do not allow them to use Hospital employees when providing services. In the interim, establish controls to prevent simultaneous assignment of Hospital employees to work for both nursing contractors and the Hospital.

4. Define the methodology that will be used to determine the number of grids and the grid order to be followed when supplementary nursing personnel are employed.

5. Ensure that nursing contractors are called in grid order, and that all calls are documented.

6. Ensure that there are reasonable and predetermined intervals between calls to nursing contractors.

7. Compare contractor sign-in sheets and employee time-sheets to prevent duplicate payments for overlapping hours, and recover any overpayments from nursing contractors.

8. Review the reasonableness of food service costs in comparison to nearby hospital facilities.

9. Designate contract managers for each service contract. Require contract managers verify that vendors comply with the terms of their contracts, and that amounts billed are for services actually received.

10. Recommendation deleted.

Accounts Payable Controls

The Center's Accounts Payable Unit (Unit) processed more than 22,000 payments totalling $56 million for the Hospital during the fiscal year ended June 30, 1992. We reviewed the Unit's procedures for processing expenditures and examined a sample of vouchers paid between April 1, 1990, and November 30, 1992. Our objective was to determine whether the Center had instituted adequate controls to prevent erroneous or duplicate payments.

The Center's Accounts Payable Procedure Manual does not establish guidelines for verification that goods and services have actually been received. We reviewed all vouchers in a sample of 112 vendor files maintained in the Accounts Payable Unit. We found that four paid vouchers had no written evidence that the vendor's invoice had been approved by the user department or that officials of the Accounts Payable Unit had obtained verbal approval. As a result, there was no assurance that the amounts paid on these vouchers were correct.

We reviewed supporting documentation for each of the four vouchers. Three of these vouchers authorized payment for contract therapy services. The Physical Rehabilitation Department routinely gave verbal approval for payment of this vendor's invoices, based upon the number of hours recorded on timesheets submitted by the contract therapists. However, department officials did not review the actual invoices and did not ensure that the rates of pay were in accordance with the terms of the contract. Furthermore, on one invoice we reviewed, the vendor billed for three hours more than were recorded on therapists' timesheets. This error was not identified and the vendor was overpaid $174.

To prevent duplicate payments, vouchers should only be prepared upon receipt of original invoices. According to officials of the Accounts Payable Unit, only they can authorize payment based on facsimiles or photocopies of invoices. In such cases, they would stamp the copy "Accepted As Original" and initial the copy of the invoice. However, during our review of sampled vouchers, we noted that this procedure was not always followed.

We identified a duplicate payment, regarding the purchase by the Center's Medical Records Department of an annual software maintenance agreement that took effect on July 15, 1992. The Medical Records Department prepared a requisition and forwarded it, along with the vendor's invoice and a copy of the service agreement to the Center's Purchasing Department. Although the

agreement cost $1,900, no purchase order was issued. The Accounts Payable Unit prepared a voucher and the vendor was paid on August 12, 1992. On August 21, 1992, the Medical Records Department sent facsimile copies of the original requisition, vendor invoice and service agreement to the Center's Purchasing Department, where a confirming purchase order was prepared. There was no evidence that the facsimile copies were stamped "Accepted As Original" or reviewed by the officials of the Accounts Payable Unit. Another voucher was prepared and the vendor received a duplicate payment. Center officials recovered the overpayment after we brought it to their attention.

Recommendations

11. Develop written guidelines that require user departments to review vendor invoices, and document approvals. Distribute these guidelines to all persons authorized to approve payment of vendor invoices.

12. Obtain supporting documentation (such as timesheets of contract therapists, receiving reports or packing slips) to ensure that goods and services have been received.

13. Recover the $174 overpayment from the contract therapy vendor.

14. Do not process payments based upon facsimiles or photocopies of vendors' invoices. Mark all paid invoices to prevent their reuse.

Supplies Inventories

The Hospital maintains inventories of supplies commonly used in its Central Sterile Supply and Central Stores units. We reviewed both units' procedures for recording the issuance and receipt of supplies, maintaining appropriate supply levels and performing physical inventories. In general, we found that the Central Stores Unit had adequate controls over its inventory procedures, with only minor discrepancies in perpetual inventory records. However, inventory controls at the Central Sterile Supply Unit (Unit) need improvement. As of December 28, 1992, the Unit valued its inventory at $881,211.

To be effective, a good system of inventory control requires the posting of all receipts and issues to perpetual inventory records, the taking of periodic physical inventories, and the reconciliation of perpetual inventory records with the results of physical counts. We physically counted a sample of 29 Central Sterile Supply items that either had a unit cost of at least $50 or a total value of the items on hand on December 28, 1992, was at least $10,000. Our sample was valued by the Hospital at $281,830 (32 percent of the recorded value of all inventory on hand as of December 28, 1992). We found that the perpetual inventory records overstated the actual quantities of 15 of these items by $91,971 and understated the actual quantities of others by $4,909. We also found that the value of three items had been overstated significantly because of unit price errors. After correcting these errors, we calculated that the actual value of our sample was only $149,945. For example, the perpetual inventory records on the day we performed our physical counts indicated that the Unit had 17,265 small vein infusion sets, each costing $3.26. In total, the Unit reported that the value of these items on hand was $56,284. We found that the Unit could only account for 6,702 sets on hand. Furthermore, Hospital officials later told us that the actual unit cost of these items was only $0.22. Therefore, the value of these items on hand was only $1,474.

We were informed by a Hospital official that most of these differences occurred because the Unit did not record all issuances or reconcile discrepancies between perpetual inventory records and physical counts. The Unit issued supplies by fulfilling requisitions prepared by authorized Hospital personnel or by refilling nursing unit supply cabinets, peritoneal/dialysis trays and isolation exchange carts to a par-stock level. Issuances of supplies requested by Hospital personnel were recorded on requisition forms and quantities of supplies placed in nursing unit supply cabinets were recorded on par-stock forms. The Unit then entered data recorded on these

requisition and par-stock forms into a computerized inventory system. However, the Unit did not record the issuance of supplies placed on peritoneal/dialysis trays and isolation carts. These supplies included disposable caps, gowns, masks, gloves, needles, specimen bags and autoclave wrappers.

One hospital official also noted that the Unit occasionally issued supplies in anticipation of receiving the requisition forms. In some cases, the expected requisitions were not submitted, and the issuances were never recorded on the inventory system. Other errors identified by Hospital officials included data entry errors and a failure to identify supplies used within the Unit, supplies loaned to or borrowed from other hospitals, or reusable equipment that was returned.

Hospital officials stated that they periodically adjusted perpetual inventory levels based on monthly physical inventory counts. However, it is unlikely that the significant number of errors we found could have occurred within one month. We also noted that the Unit did not investigate or document the errors causing the discrepancies.

One major objective of a system of inventory control is to insure that sufficient quantities of supplies are on hand to meet anticipated needs without tying up funds needlessly in excessive stock. In order to maintain adequate control over the level of stock, standard order quantities and reorder points must be established, a practice the Unit has yet to undertake. Instead, Unit staff based their purchases on physical counts of supplies on hand, and on their judgment and experience.

Based on our computation of the average daily usage of 16 sampled items with total stock valued at $10,000 or more on December 28, 1992, we calculated the number of days the quantities we had physically counted would last. We found that the Hospital was storing excessive quantities (more than a 90-day supply) of four of these items. A fifth item in stock was not used at all during the 1992 calendar year. The excess items we identified in our sample had cost the Hospital $15,895. State funds were needlessly tied up in this excess inventory.

Recommendations

15. Record all receipts and issuances of supplies from inventory.

16. Investigate all differences between perpetual inventory records and physical inventory counts. Retain documentation supporting any required adjustments to perpetual inventory records.

17. Do not issue supplies until requisition forms are received.

18. Verify the accuracy of data entered on the computerized inventory system.

19. Develop standard order quantities and reorder points for all items in inventory.

Equipment Controls

The Center maintains equipment inventory records as part of SUNY's Property Control System (PCS). The PCS is a computerized database of all equipment owned by SUNY, including items purchased with State funds, Certificates of Participation, and Research Foundation funds. The Center's Property Control Unit (Unit) is responsible for performing periodic physical inventories and for initiating changes in the PCS system.

As of December 31, 1991, the Hospital had major moveable equipment costing more than $32 million, a significant increase from prior years ($28 million as of December 31, 1990, and $25 million as of December 31, 1989).

We reviewed the Center's procedures for recording new equipment items on the property control system from April 1, 1990, through September 30, 1992. We also reviewed transactions that occurred during that period involving Hospital equipment purchased with State funds. During our audit, the Center was in the process of taking a complete physical inventory of all equipment to determine whether the PCS accurately reflected the items on hand. To avoid duplication of effort, our scope was limited to additions of equipment to the PCS and physical security over the equipment.

Our objectives were to determine whether equipment items purchased for the Hospital with State funds during our audit period were recorded on the PCS and to determine whether the Center had adequate procedures to ensure that State assets removed temporarily from the Hospital were returned.

In accordance with guidelines contained in SUNY's Property Control User Manual (Manual), the Property Control Unit reviews all purchase orders to determine which items need to be recorded on the PCS. The Unit assigns each item an asset number, which is entered in an asset register, and initiates an equipment addition form. The Unit then sends the form to either an equipment coordinator in the user department or the Center's Scientific and Medical Instrumentation Center (SMIC). The user department or SMIC, in turn, records identifying information on the equipment addition form, such as the item's serial number and its location, and returns a copy to the Unit. When the form is returned, the Unit places an identification tag on the item and enters the asset into the PCS.

However, we found that the Unit did not ensure that all equipment addition forms were completed and returned. We selected a sample of 20 purchase orders for equipment purchased for the Hospital between April 1, 1990, and September 30, 1992. We found that two purchases of seven items costing more than $53,000 had never been tagged or entered into the PCS. A Property Control official stated that his copies of the two purchase orders had been filed erroneously with documents from completed PCS transactions before the Unit had received sufficient information about the items. As a result, the Center did not establish accountability over these seven items. Furthermore, because they were not recorded in the PCS, depreciation on these seven items was not factored into the Hospital's reimbursement rates.

The Manual also requires that employees who remove State property from the Hospital present a properly-completed equipment removal form to the Public Safety Officer at the building exit. This three-part form identifies the employee removing the equipment and the items to be removed, documents approval by the appropriate department head, and indicates when the items will be returned. The Public Safety Officer is required to collect two of the three copies of the form and submit them to the Public Safety Office. The Public Safety Office retains one copy and forwards the second copy to the Property Control Unit. When the item is returned, the employee is required to present the third copy of the form to the Officer at the entrance. The Public Safety Office is required to review these forms monthly to identify items that have not been returned within a month of the expected return date, and notify the Property Control Unit about any outstanding items. The Property Control Unit is then expected to contact the appropriate equipment coordinators to determine the status of the items that have not been returned.

We found that forms were not always approved by the appropriate department head and that the Public Safety Office did not forward copies of the forms to the Property Control Unit. Nor did the Public Safety Office notify the Property Control Unit of items not returned within one month of the expected date of return. In fact, the Public Safety Officer responsible for this function has not reviewed equipment removal forms since July 1991. We sampled 8 items that had been removed from the hospital and found that one item, a computer, was still outstanding eight months after it had been removed. Since the Property Control Unit had not been notified of outstanding items, it could not attempt to locate them.

Recommendations

20. Property Control Unit: Develop a tracking system to ensure that all PCS-eligible equipment recorded in the asset register is also given an identification tag and recorded on the PCS.

21. Public Safety Office: Forward a copy of all equipment removal forms to the Property Control Unit daily. Review these forms on a monthly basis and notify the Property Control Unit of items that have not been returned within one month of the expected date of return.

Major Contributors to This Report

Marvin Loewy, Audit Manager
Martin Chauvin, Audit Supervisor
David Hoffer, Auditor-in-Charge
Gene Brenenson, Staff Auditor
Ian Martin, Staff Auditor
Mary Taylor, Staff Auditor
Marticia Madory, Report Editor

State University of New York
State University Plaza
Albany, New York 12246
Office of the Senior Vice Chancellor
Division of Administrative Affairs

December 29, 1993

Mr. Robert H. Attmore
Deputy Comptroller
Office of the State Comptroller
The State Office Building
Albany, New York 12236

Dear Mr. Attmore:

In accordance with Section 170 of the Executive Law, we are enclosing the comments of the State University of New York Health Science Center at Brooklyn and SUNY Central Administration regarding the draft audit report on Selected Contracting and Expenditure Controls, SUNY Health Science Center at Brooklyn (93-S-50).

Sincerely,

Harry K. Spindler
Senior Vice Chancellor
Division of Administrative Affairs

Enc.

Health Science Center at Brooklyn Comments

1-2. We agree.

3-6. Notwithstanding the State's lowest-qualified bidder requirements, the Hospital's primary consideration in contracting for and using per diem nursing agencies must be the quality of patient care, which depends on the reliability with which those agencies will supply qualified nurses in a timely manner. This reliability can be assessed only partially before contract execution; only by actually using an agency can Nursing management learn whether or not that agency will supply qualified nurses timely and reliably.

University Hospital/Brooklyn's Nursing managers have made every effort to use the lowest-bidding per diem nursing agencies available. The actual performance of those agencies, i.e., whether they would in fact supply the nurses UHB needed, quickly became evident. When agencies failed to supply the nurses needed, UHB Nursing management had no choice but to go to other contractors. Not surprisingly, those contractors who paid (and charged UHB) higher rates were the ones for whom per diem nurses chose to work; consequently those were the agencies who could fulfill their contractual obligations. The lowest-cost agencies were unable to reliably supply qualified nurses.

The Health Science Center is confident that it acted in the most effective manner in securing nursing services to augment its in-house personnel.

7-9. We agree and will monitor contact payments for appropriateness.

10. We disagree. The auditors are not correct in stating that the contract for temporary financial management services "...does not require the Hospital reimburse the Foundation for wages and fringe benefits paid to employees while on leave...".

Note *

Paragraph two of the current agreement (C300084), in the form of an MOU approved by the State Comptroller, provides that all RF personnel policies apply. This includes paid leave.

11,12. We agree.

13. Implemented.

14. We agree. Invoices will be stamped paid to prevent their reuse.

15-19. We agree and will ensure that appropriate controls and recordkeeping are maintained over supplies inventory.

* See State Comptroller's Notes, Page B-3

20,21. We agree.

State University of New York Comments

We are in general agreement with the recommendations and the Center's responses. However, we agree with the Center's response regarding the contracts with The Research Foundation.

State Comptroller's Note

Recommendation 10 and the related finding in the body of the report have been deleted from the final report.